Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name:
WAUSAU UNDERWRITERS INSURANCE

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number:
M4-12-2867-01

MDFR Received Date
May 11, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary with the request for medical fee dispute resolution.

Amount in Dispute: $273.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claimant is requesting reimbursement for prescription medications. The receipt submitted for 1/23/2012 was previously submitted and was reimbursed to the claimant with check # 96231588 issued on 1/30/12. The total amount of that check was $191.22 as there was also $99.00 in mileage reimbursement paid at the same time. The charges for 2/21/12 and 3/19/12 have also now been reimbursed under check # 96773396 in the amount of $215.94 which include3s $33.30 in mileage as well. Copies of the payment screens including Issue Date and Check # are attached.

Response Submitted by: Liberty Mutual Insurance Co., PO Box 3423, Gainesville, GA 30503

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 23, 2012 February 21, 2012 March 19, 2012	Out –of-Pocket expenses for Prescription Medication	$273.96	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for injured employees to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.270 sets out the procedures for injured employees to submit workers' compensation out-of-pocket expenses to the insurance carrier for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits were not submitted by either party.

Issues

1. Did the requestor submit the out-of-pocket expenses for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor submit documentation to support the disputed bills were submitted to the carrier in accordance with Texas Labor Code, Section §133.270(a)(2) and (b)?
3. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to 28 Texas Administrative Code §133.307(a) the requestor filed the request for medical fee dispute resolution in the form and manner required by the division. Therefore, the dispute is eligible for review.

2. Pursuant to 28 Texas Administrative Code §133.270(a), an injured employee may request reimbursement from the insurance carrier when the injured employee has paid for health care provided for a compensable injury, unless the injured employee is liable for payment as specified in: (1) Insurance Code §1305.451, or (2) §134.504 of this title (relating to Pharmaceutical Expenses Incurred by the Injured Employee); and (b) The injured employee's request for reimbursement shall be legible and shall include documentation or evidence (such as itemized receipts) of the amount the injured employee paid the health care provider the requestor submitted documentation. The injured employee submitted documentation to support that the requirement of the rule was met.

3. Two payment screens were submitted by the insurance carrier showing that the injured employee was reimbursed. Review of the payment screens confirm that check number 96231588, issued on January 30, 2012 in the amount of $191.22, this amount included $91.32 for the prescription medication, Hydroco/APAP 10-325 MG; the subsequent check, number 96773396, issued on May 31, 2012 in the amount of $215.94, this amount included $182.64 for the prescription medication, Hydroco/APAP 10-325 MG. The disputed amount has been reimbursed to the injured worker and no further action is required.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		June 15, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.